SCHOOL DISTRICT OF LOYAL
JHCD-R
Approved: 8/18/10

INSTRUCTIONS/CONSENT FOR ADMINISTERING PRESCRIPTION MEDICATION

Dear Parent/Guardian:

If it is necessary for school personnel to administer prescription to your child at school, please complete and sign the lower section of this form and present this form to the prescribing physician, dentist, optometrist, physician assistant, advanced practice nurse prescriber, dentist, or podiatrist. Ask him/her to complete and sign the top section of this form and prescribe duplicate bottles of said medication. One bottle will be kept at home and the other at school under the care of the person responsible for giving the medication. Both bottles must have the following information: (1) the name and telephone number of the pharmacy; (2) the student's name; (3) the name of the prescribing practitioner; and, (4) the name of the drug, dosage and number of times to be given.

A designated school staff member shall supervise the taking of the medication. It shall be given at the time conforming with the practitioner's indicated dosage schedule. Thank you.

_____
Building Principal

Practitioner's Request for Giving Medication at School

I hereby request a school staff member to see that _____ receives his/her medication in accordance with the following instructions:

1. Name/Type of Medication_____
2. Dosage/Amount to be given_____
3. Frequency/Times to be administered _____
4. Duration (week, month, indefinite, etc.)_____
5. Anticipated reaction to medication _____
6. Reason for this medication _____

Signature of Health Care Provider _____

Parent/Guardian Consent for Giving Medication at School

Student Name_____Date of Birth _____

Address _____Telephone_____

School _____Grade/Teacher_____

I hereby grant permission for the above named school to supervise the medication routine prescribed herein for the above named child.

Signature of Parent_____ Date_____